

Occupational violence and staff safety in general practice

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Background

The recent death of a Victorian surgeon who was assaulted by a member of the public when leaving work has re-highlighted the risk and potential cost of violence experienced by healthcare workers.

Objectives

The aim of this article is to outline the risk of occupational violence experienced by doctors, and general practitioners in particular, and to discuss practical measures that can be taken to manage this risk.

Discussion

The majority of doctors have experienced aggression or violence in their workplaces in the past 12 months. Risks for violence include elements of workplace design, policy and procedures, and client factors. A series of practical tools designed to assist the assessment and management of risk of occupational violence are discussed.

Given the nature of our work, all health practitioners who deal directly with patients are exposed to some risk of violence in the workplace. Our patients and their families are people with different strengths, weaknesses, attitudes and expectations. People seek healthcare, for the most part, when things are not going well in their lives. They may be sick themselves, or under extreme pressure from a variety of psychosocial circumstances. Under normal situations people can act in aggressive or violent ways. When stressed, this behaviour is likely to be more common.

Recent instances of violence toward healthcare workers, including the tragic death of a Victorian surgeon, has brought this issue to greater public prominence.¹ However, most healthcare workers would acknowledge that violence at work is not an issue that has developed only recently. It is critical for all healthcare providers and institutions to face and address the risk of occupational violence. This imposes significant costs to the health and careers of those working in healthcare.^{2,3} It is of benefit to everyone to reduce the frequency and severity of occupational violence.

Rates of violence towards healthcare professionals

The extent of occupational violence towards healthcare workers in Australia is not completely known. A report conducted by the Victorian

Auditor-General⁴ highlighted major issues with under-reporting of violence at work. Numerous factors were identified as significant contributors, including time-consuming reporting mechanisms, normalisation of violent behaviour in unwell patients, and poor confidence that reporting will lead to positive changes at a systems level.

In the broader Australian context, national data from the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey⁵ has highlighted the extent of the issue. In this study, 9951 Australian doctors, across all professions and stages of training, participated in a survey conducted between 2010 and 2011. Among numerous other questions, they were asked about their experiences of verbal and physical aggression and violence (defined in Box 1) in their workplaces. A total of 70.6% reported experiencing verbal or written aggression, and 32.3% reported experiencing physical aggression, in their previous 12 months of practice.⁶ For those in general practice, the rates were lower than in their hospital specialist colleagues, although 12-month prevalence rates were still alarmingly high – incidents of verbal aggression (54.9%) and physical aggression (23.4%) were a substantial concern.

Of note in this study was the source of this violence. Although patients or their carers were the highest sources of violence, approximately 15% of general practitioners (GPs) reported

experiencing written or verbal violence, and approximately 4% reported physical violence, from co-workers in the past 12 months.⁶

Data specific to GPs are also available from a national survey conducted between 2009 and 2010.⁷ In this nationally representative survey of 804 GPs, 58% reported verbal abuse and 18% reported property damage or theft occurring in their previous 12 months of practice. Lesser, although still significant, rates of physical abuse (6%) and sexual harassment (6%) were identified by reporting GPs. These data demonstrated numerous factors associated with being at higher risk of certain types of violence. For example, GPs working full time, in large group practices or with fewer years of work experience were at higher risk of verbal abuse, whereas female GPs reported a more than four times greater risk of sexual harassment than their male colleagues.⁷

These data complement a relative paucity of data that was previously available regarding the level of occupational violence experienced by Australian GPs. In an article on the subject published in this journal in 2010, Forrest and colleagues⁹ reviewed four studies that investigated levels of violence in Australian general practice. Although there were issues with data quality due to sampling from smaller regions and/or generally low sample sizes, the data suggested that rates of any form of violence experienced by Australian GPs over a 12-month period were 48–63.7%.⁹

After-hours and home visits – Times of particular risk?

Certain aspects of practice may confer higher risk of exposure to violence, including home visits and after-hours work.^{7,9} A recent study exploring the experience of doctors working for the National Home Doctor Service found this to be a time of increased risk. The study incorporated responses from 172 doctors, including >70% international medical graduates. Approximately 85% of doctors normally worked in general

practice, and approximately 45% were fellows (vocationally registered). Of those surveyed, only 43% had instituted any form of protective strategy when undertaking an after-hours home visit. Female doctors were almost five times more likely to institute protective mechanisms, and Australian-trained doctors were approximately 65% less likely overall than those not trained in Australia to institute protective mechanisms. A significant proportion of doctors were either unaware of there being any risk (6%), or knew there was a risk but were unaware of the options available to reduce the risk (31.8%). The most common protective mechanism used was that of chaperones or security personnel (34.1%).¹⁰

Other members of the practice team

GPs should be aware of the extent that violence affects other employees in their practice. Allied health staff and practice nurses are all at risk, as are other support staff. For example, surveys of the violence experienced by receptionists in primary care conducted in the UK show that more than two-thirds of receptionists had experienced abuse in their role during the past 12 months.^{11,12} Qualitatively, reception staff report that either direct or phone verbal abuse is common, and that these experiences had significant effects on their psychological and emotional wellbeing.¹³

An approach to reducing occupational violence

Reducing the risk of violence in general practice requires action at personal and practice levels. All practitioners should commit to developing a multi-level response that includes the design of work environments, the policies that govern how staff work, and training to ensure staff are best equipped to deal with potentially violent situations.

Two Australian resources to assist individuals and practices to develop a multi-level response are worthy of

Box 1. Workplace aggression as defined in the MABEL study⁶

- Verbal or written abuse, threats, intimidation or harassment
 - eg ridicule, abusive email, racism, bullying, contemptuous treatment and non-physical threats or intimidation
- Physical threats, intimidation, harassment or violence
 - eg a raised hand or object, unwanted touching, damage to property and sexual or other physical assault

highlighting. The first is the recently released report from WorkSafe Victoria, *Prevention and management of violence and aggression in health services*.¹⁴ The second is the 2015 Royal Australian College of General Practitioners (RACGP) report, *General practice – A safe place*.¹⁵ Both reports highlight numerous factors that may contribute to an increased risk of workplace violence (Table 1).

Addressing your personal safety

Practitioners must prioritise their own safety and take steps to minimise risk. As stated in the RACGP report, 'Violence rarely comes out of the blue',¹⁵ and assessing your own safety during consultations is a good place to start. Considerations before, during and after a consultation are highlighted in Table 2. Another tool useful for practitioners is the staff survey incorporated in WorkSafe Victoria's report.¹⁴ The survey provides a systematic method to assess whether your workplace has appropriate measures to assist with reducing violence risk.

Addressing the safety of your practice

Practice owners have a responsibility to ensure staff, including those visiting the practice even for short periods (eg medical students, visiting specialists), are safe in the workplace. Various occupational health and safety laws in Australia confer liability to employers if they have failed to 'identify and eliminate or control all risks associated with violence as far as is reasonably

Table 1. Risk factors by category that may increase risk of occupational violence^{14,15}

Category	Risk factors
Workplace design	<ul style="list-style-type: none"> • Poor delineation between staff-only areas and patient areas • Lack of controls in accessing staff-only and patient areas (eg easy free access to all) • Poor lighting, crowding and excess noise • Poor access to exits, toilets and amenities
Policies and work practices	<ul style="list-style-type: none"> • Protracted waiting times • Poor customer service from all staff • Deficits in staffing levels, or inadequate skills mix • Ineffective mechanisms to warn and ultimately deny service to patients with repeated behaviours of concern
Client factors	<ul style="list-style-type: none"> • Current illness with physiological imbalances or disturbances • Active intoxication, substance dependence, misuse or abuse • Psychosocial stressors • Previous poor experiences with healthcare services • Past history of violence

Table 2. Considerations for practitioners while consulting^{14,15}

Stage	Considerations during consultation process
Before the consultation	<p>Consultation room set-up:</p> <ul style="list-style-type: none"> • Do you have a quick exit route? <ul style="list-style-type: none"> – Are there two exits? – Is your chair, or the patient's, nearer the exit? • Do you have a distress alarm or other mechanism to call for assistance? • Are there any potential weapons accessible to patients in your consulting room (eg heavy/sharp objects)? <p>Preparation for the consultation:</p> <ul style="list-style-type: none"> • Are there flags on the medical record for previous violence from this patient? • Are there other client risk factors present? (Table 1) • Is a chaperone required?
During the consultation	<p>Signs of increasing agitation:</p> <ul style="list-style-type: none"> • Are warning signs of violence present, including <ul style="list-style-type: none"> – veiled or overt threats – violent gesturing or intense interpersonal communication (eg staring, shouting) – increased psychomotor agitation (eg restlessness, pacing) <p>De-escalate versus end consultation:</p> <ul style="list-style-type: none"> • Is it safe to attempt de-escalation techniques? <p>For example,</p> <ul style="list-style-type: none"> – Does remaining calm, allowing silence, using reflective questioning lead to decreased agitation? – Does the patient want to problem solve with you? • If agitation continues to escalate: <ul style="list-style-type: none"> – Can you safely advise that you are ending the consultation? – Do you need to call for assistance, or take a short break to get help?
After the consultation	<p>Patient care and safety of others:</p> <ul style="list-style-type: none"> • Has the patient left the premises safely? • Are others in your practice safe? <p>Documentation of risks:</p> <ul style="list-style-type: none"> • Have you appropriately documented what occurred, and placed a flag on the patient's file where appropriate? • Is this a one-off event, or repeat of previous incidents for this individual? <ul style="list-style-type: none"> – Are warning letters appropriate? Development of acceptable behaviour agreements?

practicable'.¹⁵ It is therefore an imperative of practice owners to take this risk seriously.

The RACGP report includes checklists for 'the practice environment' and for 'the GP and practice team', which can be used to improve the safety of clinics.¹⁵

In addition, Worksafe's organisational self-assessment tool¹⁴ can help practice partners who employ others to identify issues that could influence the risk of violence in their workplaces. Important factors include ensuring that:

- there is an adequate policy framework with procedures and documented approaches to reduce workplace violence in your practice
 - appropriate information is provided to patients, families and others accessing your service about how violence will not be tolerated
 - there are processes in place to access assistance when required (eg alarms)
 - there is a system for reporting all episodes of occupational violence and investigation by practice management.
- Education and training are vital. Programs developed need regular evaluation and review to ensure they meet the current needs identified. For example, your workplace may have excellent processes in place to address violent incidents once they have occurred, but staff may feel unprepared or lacking in communication and de-escalation skills to address situations

before they turn violent. A process to develop a regular, recurring education and training program, as detailed in Table 3, will be of benefit in reducing violence risk.

Conclusion

The risk of occupational aggression and violence in healthcare is one that all practitioners and employers must take very seriously. Recent serious incidents of violence should focus our minds to tackling this issue. Fortunately, there are many steps we as practitioners and employers can take to help reduce and manage this risk. In our very human vocation a risk of violence will always be present – it is up to us to use the tools available to ensure that, as much as possible, it does not stop us doing our jobs.

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Table 3. Designing an education and training program¹⁴

Stage of program design	Tools and/or key content
Undertaking a needs analysis	<ul style="list-style-type: none"> • Conduct a staff survey to assess incidents and areas of risk • Use risk calculators, such as WorkSafe's exposure to aggression risk calculator, to assess risk across different areas of your practice¹⁴
Construct an education program based on their relative risk of exposure	<ul style="list-style-type: none"> • Key content: <ul style="list-style-type: none"> – Risk factors, clinical and non-clinical, for violence in healthcare workplaces – Identification of signs that risk is escalating and violence may occur – Strategies to improve communication with reduce risk – Factors that can help prevent violence in workplaces – Your workplace policies around violence and aggression – What to do in an emergency and after an incident occurs – Reinforcement that staff have a right to feel safe and to withdraw at any time
Evaluate and embed regular refreshers into practice activities	<ul style="list-style-type: none"> • Use the WorkSafe post-evaluation training tool¹⁴ to assess effectiveness and ongoing needs • Develop a regular schedule to cover key topics at least annually

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